STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

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POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to modify care interventions when they became aware a resident was self adjusting the tension on a fracture brace to his right hand. The facility failed to identify risk factors related to the use of a fracture brace. The facility failed to complete a wound assessment, failed to initiate a treatment plan and failed to notify the physician and family when a resident's skin breakdown was identified The facility failed	S9999		

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	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 to implement pressure relieving interventions (monitoinrg and repositioning) to prevent the development of a pressure ulcers This failure resulted in diminished circulation to R4's right fifth digit and the tip becoming necrotic. This applies to 4 of 9 residents (R3, R4, R9, R11) reviewed for pressure ulcers in the sample of 12. The findings include: 1. R4's hospital Emergency Room documentation dated July 22, 2015 at 8:21 PM shows "closed fracture of metacarpal bone." R4's nurse note dated July 22, 2015 shows "arrived back at facility per our van, right forearm and hand has soft cast immobilizer in place..." Z2's (Orthopedic Surgeon) office note dated July 27, 2015 shows R4's soft brace was replaced with a Exo fracture brace (hard brace immobilizing smallest finger and extending over R4's forearm). R4's skin integrity care plan date July 27, 2015 shows R4 is at risk for skin breakdown related to decline in mobility, and has splint to right hand/wrist. The skin integrity care plan shows "check for skin irritation from brace and CMS [circulation, motor function, sensation] to fingers on right hand." R4's nurse note dated August 11, 2015 at 3:30 PM, shows "CNA [Certified Nurse Assistant] reported that when helping him [R4] to bed for a nap that he had [his] brace tight and that pinky finger on right hand, tip of it was black, upon my assessment he had brace tight and twisted with little finger bent inside of hand with straps of	S9999		

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POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

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S9999	Continued From page 3	S9999		

brace twisted." The incorrect placement of the brace lead to the development of a neurotic pressure area on R4's pinky finger.

Z2's office noted dated August 12, 2015 shows R4 "is definitely going to need some sort of revision amputation to his left small fingertip, but I would watch this for another couple of weeks just to let it fully demarcate...would like to see him in about 2 weeks so we can reevaluate the small finger and decide the level of amputation."

Z2's noted dated September 24, 2015 shows treatment option for R4's finger includes "an amputation most likely at the middle phalanx level versus continued observation expectant treatment..." and with expectant treatment "there is a possibility that the finger may just wither away and fall off, and if it leaves an exposed bony area, might need amputation at that time..."

R4's Physician Order Sheet dated October 1, 2015 shows diagnoses to include: Dementia with impaired safety awareness, delirium, fracture of right metacarpal, and Parkinson's and dementia with poor trunk control and poor safety awareness.

R4's MDS of October 9, 2015 shows R4 is cognitively impaired and requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting. R4's skin risk assessment dated August 6, 2015, and October 9, 2015 shows R4 is high risk for skin breakdown, and has a potential problem with fiction and shear..

R4's Weekly Wound Tracking dated October 18, 2015 shows a necrotic right pinky measuring 2.5 cm x 1.5 cm. No weekly assessments of R4's pinky have been completed since October 18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 2015 (over 2 weeks ago). On November 3, 2015 at 10:00 AM, R4 had his fingers curled towards his palm and resting on the lap tray. On November 3, 2015 at At 1:00 PM, R1 was in his wheelchair, and E2 (DON) helped R4 open his right hand. The tip of R4's right small finger was completely black all the way around the finger, with a small flap of dried black tissue present. R4 pulled his hand away from E2 and said "no" when she attempted to touch it. On November 3, 2015 at 11:15 AM, E16 (LPN) when they found the brace too tight on R4, his hand was inside his brace with his pinky laying flat, squeezed against the inside of his hand (palm). E16 said the tip of R4's finger was black and necrotic. R4's brace was as tight as it could go. E16 continued to say R4 would "play" with the brace and say "I just want it off". R4 was caught turning the dial before they found the injury, and she was unsure how long it had been since the brace had been checked, before finding the injury. On November 3, 2015 at 3:00 PM, E7, Certified Nurse Assistant (CNA) said R4 would fidget with the dial on his brace, and would twist and turn it. E7 said R4 fidgeted with the brace quite often, and he "was always playing with some part." and E5 (CNA) said she loosened R4's brace to wash his hands and then tighten it back up after she was done. On November 3, 2015 at 12:35 PM, E16 said when the necrotic area was found, the brace was all twisted and didn' t look like it was on correctly. E16 said at that time the tip of R4's fingers was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

necrotic. E16 said they would redirect R4 if they saw him playing with the brace but no interventions were in place to ensure the brace fit properly.

On November 3, 2015 at 12:45 PM, E14, Licensed Practical Nurse (LPN) said the nurses should adjusted the brace. E14 said if R4's brace was tight enough he would not have been able to get his fingers inside the brace.

On November 4, 2015 at 8:20 AM, Z2 (orthopedic surgeon) said, normally a resident would not get their hand inside the brace. Z2 said he was not aware R4 would mess or fidget with his brace and the first he was notified about that was after the injury occurred. Z2 said the brace could have been discontinued, and R4 could have been put in a cast.

The October, 2006 facility policy "Preventative Skin Care" states
"Ensure proper fit of wheelchairs, splints, braces, prosthesis, etc"

2. On November 2, 2015 at 8:06 PM, E4 and E8 (Certified Nurse Assistants-CNAs) transferred R4 from his wheelchair to the bed. E4 and E8 removed R4's pants, and incontinence brief. R4's incontinence brief was saturated with urine, and his bottom was red and discolored. E4 and E8 said R4 was toileted before supper (over 3 hours prior). E4 and E8 cleaned R4's bottom with a wet cloth and R4 said "oh my god that hurts, damn near killed me. E4 said yes, his bottom is usually red from sitting, and he doesn't have much of a bottom. E4 said they usually get R4 up around 2:30-3:00 PM and toilet him before supper. E4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 6	S9999		

said R4 stays in his wheelchair for meals, and is only out of his chair when he is toileted before going to bed at night.

On November 3, 2015 at 8:30 AM, R4 was in a wheelchair outside the nurse station asking for help with his "crotch" and saying "it hurts." E6 (CNA) and E14 (Licensed Practical Nurse-LPN) transferred R4 from his wheelchair to the toilet and R4 said "my crotch is killing me." E6 removed R4's incontinence brief and R4 was incontinent of stool and urine. E6 and E14 stood R4 in the bathroom and cleaned R4's bottom with a wet cloth. R4 yelled "ow, ouch" when cleaned between his bottom and scrotum. There was red blood on the cloth after wiping from the scrotum to the rectum. R4 had an open area between his scrotum and rectum and E14 said the blood was coming from an open spot below his scrotum, it looked like a tear, and "that could explain why his crotch hurts." E6 said R4 does not usually lay down after breakfast because he is too agitated, and R4 was transferred back to his wheelchair after toileting. E6 and E14 did not offer to lay R4 down prior to taking him out in the hall.

On November 3, 2015 at 9:50 AM, E14 said R4 has redness around his rectum and an open area between his scrotum and rectum. E14 said this was caused because R4 is incontinent of stool and urine, and R4 should be toileted frequently, at least every 2 hours.

R4's nurse notes dated November 3, 2015 at 10:30 AM shows "resident having complaints of pain to 'crotch' this am. Assessed area, observed small 0.25 cm open area between scrotum and rectum."

On November 4, 2015 at 1:10 PM, E15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 (Restorative Nurse) said bowel and bladder incontinence causes skin to become fragile and makes it easier for skin to breakdown and shear. R4's skin integrity care plan dated July 27, 2015 shows R4 is at risk for skin breakdown related to decline in mobility, and episodes of incontinence. The care plan shows interventions to assist to reposition at least every 2 hours and as needed, and offer naps in bed after meals. The October, 2006 facility policy "Preventative Skin Care" states "to provide preventive skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, and well groomed, and free from pressure ulcers." "Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two (2) hours." "Keep incontinent residents clean and dry." 3. On November 2, 2015 at 7:30 PM, R11 was transferred to bed by E7 and E11 (Certified Nursing Assistant - CNA). The seat and crotch of R11's pants were wet when R11 was moved from the wheelchair to bed. The incontinence brief was saturated and had strong urine odor. R11's buttocks were creased from the incontinence brief. An approximate 1 inch opening with oozing red blood was noted on the left buttocks along a crease line from the brief. E7 cleansed the area, and stated R11 has very delicate skin. No barrier cream was applied to the buttocks. E7 stated R11 had been in his chair since the start of her shift at 2 PM. R11's wheelchair did not have a pressure relieving cushion.	S9999		

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	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 On November 3, 2015 at 9:25 AM, E10 (CNA) and E2 (Director of Nurses - DON) observed an open area on R11's left buttock. The area was dry with crusty edges. E2 measured the open area at 2.5 cm in length. E10 (CNA) stated there was no report this morning of a new opening on R11's buttocks. E2 (DON) stated the facility procedure includes the CNA staff to report new openings to the nurse on duty. Barrier cream can be applied until the nurse obtains a treatment order from the physician. The nurse does the assessment initially and the wound is monitored weekly until healed. On November 3, 2015 at 9:40 AM, E16 (Licensed Practical Nurse - LPN) stated she was not aware of a new opening on R11's buttock, nothing was said in report this morning. E16 reviewed R11's medical record and stated she found no documentation about a new wound. The Minimum Data Set of August 26, 2015 shows R11 is at risk to develop pressure and has no unhealed pressure ulcers. The risk assessment for development of pressure ulcers shows R11's score of 16 (16 and less = high risk). The care plan for R11 shows to reposition R11 every 2 hours and to use a pressure reducing cushion in the wheelchair; and to apply house stock incontinent barrier cream to perineal area with every incontinent episode. 4. The facility's undated Profile Face Sheet show R3 was admitted to the facility on January 19, 2011 with the following diagnoses: Alzheimer's, difficulty walking, muscle weakness, and a personal history of falls. R3's MDS (Minimum Data Set) dated August 19, 2015 show R3 is dependent on 2 staff members for transfers, positioning side to side, and body positioning. The	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

MDS also shows R3 is dependent on 2 staff for toileting and has impairments on both sides of his upper and lower extremities.

On November 2, 2015 at 7:40 PM, E8 and E4 (Certified Nursing Assistants-CNAs)transferred R3 using a mechanical lift. R3 was visibly saturated with stool and urine through his incontinence brief, pants, and the lift sling. E8 and E4 verified that R3 had soaked through his brief and pants, and that the sling under R3 was wet due to urine. E8 and E4 removed R3's pants and incontinence brief . R3 had a small irregular shaped opening to his left buttocks. E8 said it was open but it is better than it was. E4 said R3 got it from sitting. There was a pink healed irregular shaped area to R3's right buttocks.

On November 3, 2015 at 8:20 AM, R3 was sitting in the dining room. R3's cardiac chair was slightly reclined back. At 8:50 AM R3 was taken back to his room. At 9:00 AM, and again at 9:30 AM, R3 was sitting in his cardiac chair in his room with the chair slightly reclined. At 9:30 AM E6 and E14 were in the hallway on the C wing. E6 apologized that it was longer than she said it would be, stating, "I have just been busy." E6 said she would let this surveyor know when they were going to do care for R3. At 9:50 AM, 11:00 AM, and 11:50 AM, R3 was sitting in his cardiac chair in his room. R3's chair was slightly reclined and R3 was in the same position during all observations from 9:00 AM through 11:50 AM. At 11:50 AM, R3 was taken down to the dining room for lunch. At 1:00 PM, E6 and E9 (CNAs) transferred R3 from his cardiac chair to his bed using a mechanical lift. E6 was removing R3's incontinence brief and said R3 had a bowel movement. R3 had been incontinent of urine and there was a large amount of loose stool in R3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

incontinence brief. E14 (LPN) entered R3's room and stated "We can look, but I checked the TAR (Treatment Administration Record) and the open area on his buttocks was healed." E6 wiped stool from R3's buttocks at that time and E14 said Oh, he does have an open area, I will go get the barrier cream. R3's left and right mid-buttocks had a dark reddened area. There was an open area located in the dark red area on R3's left buttocks. R3's right buttocks had an area in the middle of the dark red area that appeared to have been open in the past, but was healed at this time. E14 said she was not sure if R3 had a previous open area on his right buttocks because she just started working on this wing. E14 said she was usually on the other wing.

On November 3, 2015 at 12:12 PM, E6 (CNA) said R3 is so stiff and cannot sit on the toilet. E6 said the CNAs usually provide incontinent care in the morning at wake up and then again after lunch. E6 said R3 is a mechanical lift and they put him in bed to provide incontinence care. E6 said she checked R3's incontinence brief between breakfast and lunch and she could tell by the color of the triangles on R3's briefs that he was not wet.

On November 4, 2015 at 9:50 AM, E2 (Director of Nursing- DON) said it is not acceptable for R3 to go from breakfast until after lunch without having incontinence care provided. E2 said that R3 should have been put in bed after breakfast and incontinence care provided. E2 also said it is not acceptable for any resident especially one with skin issues to be left in the cardiac chair in the same position from 8:30 AM until after lunch. E2 said it is not acceptable for the CNAs to rely on the color of the incontinent briefs to determine if the resident is incontinent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

On November 3, 2015 at 12:12 PM, E15 (MDS Coordinator/Restorative Nurse) said incontinence care for R3 is in the morning when they get him up, after meals, and at night. E15 stated, the "Day staff check to see if he is wet, if not, they reposition him."

On November 4, 2015 at 9:25 AM, E14 (LPN) said the TAR (Treatment Administration Record) showed that R3 had a 0.5 cm circle area on October 24, 2015 that was resolved on October 28, 2015. E14 stated the only treatment on the TAR in October was barrier cream as needed. E14 also stated, "I don't see any documentation on the TAR for skin checks." E14 said she did not see any documentation in the nursing notes regarding R3's open area until November 3, 2015 (after observing that the area on R3's left buttocks was open with this surveyor).

On November 4, 2015 at 9:50 AM, E2 (DON) said either herself, E15 (MDS Coordinator/Restorative Nurse), or E12 (2nd shift Registered Nurse) determine if an open area is due to pressure or other causes. E2 said they let the doctor know what the area looks like and sometimes the doctor will tell them (facility staff) if they (the doctor) think it is due to pressure or not.

On November 4, 2015 at 3:03 PM, E12 (2nd shift Registered Nurse) said she had not looked at R3's open area and documented on it. E12went to assess the open area on R3's left buttocks. E12 stated, "I think the cause of the open area on the left buttock is due to shear because he is always sliding down in the (cardiac) chair." E12 stated, "I would not expect him to be left in his chair from breakfast until 1:00 PM. He should be laid down after all meals, he has had chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

problems with that area." E2 pressed on the reddened area on R3's left buttocks to check for blanching. E2 had to press on the reddened area 2 times in order to return a very faint blanching. E2 said "it is very faint but it blanched."

On November 6, 2015 at 8:25 AM, E2 said the desired outcome is that you would want to see an immediate blanching response. E2 said having to press 2 times and only getting a faint response would indicate an inadequate blood supply to the area. E2 said she believed R3's incontinence/moisture caused the open area on R3's left buttocks. E2 said a decreased blood supply to an incontinent, moisture related area can decrease the skin's strength and contribute to the open area. E2 said if R3 is sitting in the same position for an extended period of time it could contribute to the decreased blood supply. E2 said she did not think the cause of R3's open area is solely due to pressure, but said pressure may have possibly played a part in the open area. E2 said there was no documentation regarding any previous open area to R3's right buttocks.

On November 6, 2015 at 8:20 AM, E15 said R3 was not able to communicate his needs. E15 said "His speech is mostly incoherent; occasionally you might be able to understand a word or two." E15 said staff have to anticipate R3's needs and monitor for non-verbal cues."

The facility's Weekly Wound Tracking sheet dated October 24, 2015 shows R3 had a 0.5 cm circle on his left buttocks. The document shows the area was resolved on October 28, 2015.

The facility's Weekly Wound Tracking sheet dated November 3, 2015 shows R3 had an area measuring 0.5 x 0.5 cm on his left buttocks. The

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	IL6007546	A. BUILDING: _____ B. WING _____	11/06/2015

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S9999	Continued From page 13	S9999		

area is listed as reopen. There is no determination on the sheet that identifies the type of wound or characteristics of the wound site.

The facility's Braden Scale for Predicting Pressure Ulcer Risk dated August 12, 2015 shows R3 was at high risk for the development of a pressure ulcer.

The facility's Preventative Skin Care Policy revised October 2006 shows "To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers." The policy shows "any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every 2 hours."

R3's ADL (Activities of Daily Living) Care Plan dated August 18, 2015 shows R3 needs extensive assistance for repositioning/bed mobility and needs help to reposition in wheelchair every 2 hours. The care plan also shows that R3 has no control of bowel or bladder and wears incontinence briefs during the day and has an incontinence pad on his bed at night. The care plan also shows that R3 is unable to sit on the toilet or commode due to poor trunk control/rigidity and is dependent on staff for incontinence care and application of barrier cream.

R3's Skin Breakdown Care Plan dated November 4, 2015 shows R3 should be repositioned at least every 2 hours and R3's incontinent brief should be changed when wet and upon rising, at night before going to sleep and after meals. The plan shows R3 should be transferred out of his cardiac

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S9999	Continued From page 14	S9999		

chair into bed after breakfast and lunch to change position and off-load pressure.

R3's TAR (Treatment Administration Record) from October 1, 2015 through October 31, 2015 shows R3 should have a daily skin check and the nurses should chart on the back of the TAR. The TAR was signed off by the nursing staff, however, the only documentation on the skin check was either a "C" for clear, or an "O" for other. R3's TAR dated October 1, 2015 through October 31, 2015 does not show a treatment for R3's left buttocks.

R3's TAR dated November 1, 2015 through November 30, 2015 show orders for barrier cream to R3's left buttocks and to monitor the open area to left buttocks until healed was started on November 3, 2015.

On November 4, 2015 at 9:50 AM, E2 said charting "O" (other) after doing the skin checks on the TAR could mean anything. E2 said the nurses should document what it is they see during the skin check.

The facility's Skin Condition Monitoring sheet revised January 2002 shows "Upon notification of a skin lesion, wound, stasis ulcer or other skin abnormality, the Charge Nurse will assess and document the findings. The document shows "Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: size, shape depth, color, presence of granulation tissue or necrotic tissue, treatment, and response to treatment."

The facility's Decubitus Care/Pressure Areas

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S9999	Continued From page 15 sheet revised May 2007 shows all areas of the TAR should be completed and the size, stage, site, depth, drainage, color, odor, and treatment should be documented. 5. On November 2, 2015, at 7:25 PM and from 7:55 PM-9 PM, R9 was sitting in his chair in his room . On November 3, 2015 at 7:25 AM, 7:30 AM, 8:15 AM, 8:45 AM, 8:55 AM, 9:00 AM, 9:05 AM, 9:55 AM, 10:05 AM, 10:20 AM, 10:30 AM, 10:45 AM, 11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:15 PM and from 2:40 PM-3:45 PM , R9 was sitting in his chair . On November 4, 2015, at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM and 8:20 AM, R9 was in his chair. No repositioning pressure relieving or toileting was observed during these times. On November 3, 2015 at 3:30 PM, E10 (Certified Nurse ' s Aide-CNA) stated that she was assigned to R9 ' s hall on this date and he was out of bed when she began her shift at 6:00 AM and she did not remove him from his chair for repositioning or toileting until 1:40 PM. E10 stated R9 ' s incontinent brief was wet when he was toileted at 1:40 PM and it takes two people to transfer/toilet this resident. On November 4, 2015 at 7:40 AM, E2 (Director of Nursing-DON) stated residents who are unable to communicate toileting needs should be toileted or incontinence care provided with am and has care, after every meal, as needed and should be checked on hourly rounds to see if incontinence care is needed. E2 stated if this toileting/incontinence care is not done skin breakdown, resident dignity and overall care becomes a concern. E2 stated repositioning of residents should occur during rounds if resident appears uncomfortable or agitated. E2 stated repositioning can occur by standing residents of	S9999		

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S9999	Continued From page 16	S9999		

offloading pressure with pillows to relieve areas that residents have been resting on. E2 stated if this repositioning does not occur skin breakdown, increased behaviors and overall care suffers.
On November 4, 2015 at 10:30 AM, Z1 (Family Nurse Practitioner-FNP) stated R9 ' s right buttock wound would be a Stage II since the area is open and incontinence and failure to reposition contributed to wound formation.
The undated facility-provided list of residents with decubitus ulcers shows R9 acquired a Stage II pressure wound to his right lower buttock while residing in this home.
The October 1, 2015 nursing admission assessment shows R9 had no open areas to his buttocks.
The October 1 and 12, 2015 Braden score for R9 was 14 which indicates R9 is a high risk for pressure ulcer development.
R9 ' s October 2, 2015 ADL (activity of daily living) care plan shows he should be assisted to turn and/or reposition in chair at least every two hours.
R9 ' s October 7, 2015 care plan shows R9 should be out of his chair at least two times per shift, assisted to reposition at least every two hours and toileting/change brief when wet and after meals. This care plan shows a shearing open area to R9 ' s right buttock on October 26, 2015.
The facility October 2006 preventative skin care policy shows that any resident identified as being high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours.
The October 12, 2015 Minimum Data Set for R9 shows he is always incontinent of bowel and bladder and requires extensive assistance of two people to transfer ,toileting, hygiene, bathing and mobility. This MDS shows R9 is rarely/never understood and rarely/never understands others,

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S9999	Continued From page 17 is aphasic (cannot speak) and has non-Alzheimer ' s dementia The October 25, 2015 wound tracking flow sheet shows R9 acquired a new open area to his right lower buttock on October 25, 2015 that measured 2.3 cm X 1.1 cm (24 days after admission). (B)	S9999		